UTAH MEDICAL PROGRAMS

A SUMMARY OF MEDICAL ASSISTANCE

PROGRAMS IN THE STATE OF UTAH

April 2005

UTAH DEPARTMENT OF HEALTH

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Information in this document is provided as a public service to community agencies. The summary is designed to give a broad overview of the programs and should not be used to determine eligibility.

BUREAU OF ELIGIBILITY SERVICES (BES)
DEPARTMENT OF WORKFORCE SERVICES (DWS)
Medical Assistance Programs Summary

Medical assistance is available to U.S. citizens and resident aliens who meet Utah residency and specific non-financial and financial criteria. Not all of the eligibility criteria is explained in this booklet. Please contact a Medicaid Eligibility Worker if you have questions about qualifying for Medicaid or any medical assistance program.

Some terms you should know -

⇨ **Assets:** Generally, any type of "property", such as cash, items easily turned into cash, and other non-cash property including bank accounts, cash on hand, vehicles or vacation homes. Each program has its own rules about counting assets. Some assets are not counted because a person would reasonably need them for normal living - for example, Medicaid programs do not count the home a family lives in as an asset.

⇨ **Deductions:** Amounts subtracted from gross income before comparing it to the applicable income limit.

⇨ **Health Plan:** A medical provider network responsible for recruiting and paying the actual medical providers. Most Medicaid recipients must enroll in a Health Plan. Recipients can select a primary doctor from among the Health Plan's providers. The Health Plan must approve some types of services before the recipient receives it. Recipients must have a referral from the Health Plan to seek services from a provider who does not belong to the Health Plan.

⇨ **Income:** Any kind of money coming into the household such as wages, child support, interest from investments or bank accounts, Social Security.

⇨ **Liens:** the State has a right to recover from the recipient's estate all Medicaid funds expended on a recipient who is 55 years of age or older if all of the following conditions are met:

1. There is no surviving spouse.
2. There are no surviving children under age 21.
3. There are no surviving blind or disabled children.

ORS may waive estate recovery when the property is the sole income producing asset and source of support for the survivors. Anyone can apply for an undue hardship consideration for other circumstances. You are not required to sign a lien when you apply for Medicaid. A lien is placed on real property only after death. For more information see the pamphlet "Estate Recovery Information Bulletin", BES PM 994.

⇨ **Medical bills as deductions:** medically necessary services for a family member that the family must pay. The bill must either be unpaid, or the family must have received and paid for the service in the retroactive coverage period or application month. Bills may be used as a deduction from income only for certain Medicaid programs.

⇨ **MWI Premium**: The cost sharing responsibility of an individual eligible for the Medicaid Work Incentive Program. It must be paid in cash.

⇨ **Prior-authorization:** Medicaid requires some medical services to be approved by Health Care Financing or by the Health Plan provider before they are given. If the Medicaid client has the service without getting it authorized, neither Health Care Financing nor the Health Plan will pay the bill.

⇨ **Retroactive coverage:** receiving medical coverage for a past period. Medicaid programs allow the person to request coverage for three months prior to the date of application. The Qualified Medicare Beneficiary program does not allow retroactive coverage.

⇨ **Spenddown:** a way for clients who have income greater than the income limits for a program to "buy" Medicaid coverage by paying cash or submitting medical bills that bring the client's income below the program limit. Not all medical programs allow clients to spenddown to become eligible.

⇨ **Traditional Medicaid, Non-Traditional Medicaid & PCN:** determines the benefits the eligible individual receives.
Card Colors: A purple card indicates Traditional Medicaid, a blue card indicates Non-Traditional Medicaid and a yellow card indicates eligibility for the PCN program.

MEDICAID PROGRAMS

1931 Family Medicaid (FM-O)

1931 Family Medicaid provides coverage for low income families with dependent children. Families must meet a deprivation of support requirement. This means the children must be deprived of parental support due to the death, absence, or incapacity of a parent. Families in which the primary wage earner is unemployed or employed less than 100 hours per month also meet the deprivation of support requirement. The household must pass two specific income tests. Households receiving 1931 FM-O may qualify for a 12 month earned income disregard when they lose eligibility because the earned income of a parent exceeds the income limit. Additionally 1931 households may qualify for 4 or 12 month Transitional Medicaid when they lose eligibility for 1931FM-O due to child support collections or earnings of a parent.

Income Tests: See the chart on the back cover.

Deductions: No deductions are allowed in the first income test.
Second test: $90.00 work allowance, $30 and 1/3 disregard*****, and child care ($200 maximum per child under age two, $175 over age two) from earned income.
*****Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Not allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive coverage is allowed.

Regular Family Medicaid (FM)

This program provides Medicaid coverage to low income families who do not qualify for 1931 FM-O because of income or other household circumstances. The household must meet the same deprivation of support requirement as the 1931 FM-O program described above. The differences between the 1931 FM-O and regular FM are that regular FM households do not have to meet the gross income test; they may spend down to the income limit to be eligible; and they may voluntarily choose to leave children out of the coverage who do not meet deprivation of support or when they do not want to count the child's income in determining eligibility. Regular FM households are not eligible for the12 month earned income disregard or for transitional Medicaid.

Income Test: Basic Maintenance Standard, see back cover.

Deductions: $90.00 work allowance, a $30 and 1/3 disregard*****, child care ($200 maximum per child under age two, $175 over age two) from earned income; health insurance premiums; some medical bills.
*****Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive is allowed.

Transitional Medicaid

Families who become ineligible for Family Employment Program (FEP) cash assistance or 1931 Family Medicaid may receive additional months of Medicaid coverage depending on the reason they became ineligible. Families who are no longer eligible for FEP or 1931 Family Medicaid because of child support can receive Medicaid for 4 additional months. Families who are no longer eligible for 1931 Family Medicaid because of earnings or hours of employment of the parent or non-parent specified relative, or because of the loss of 1931 Family Medicaid time limited income disregards can receive up to 12 months of continued Medicaid coverage. In addition, families who are no longer eligible for FEP because of earnings of the parent or non-parent specified relative might receive up to 12 months of continued Medicaid coverage. A household must meet certain income and reporting requirements to qualify for transitional Medicaid.

Non-Parent Caretaker Relative (FM)

An adult who is caring for a relative child, but is not the parent of the child, may qualify to receive Medicaid. The adult must meet the Family Medicaid eligibility criteria except for deprivation. The caretaker relative's spouse and dependent children cannot be included on the program unless they meet deprivation. Income and assets of the excluded spouse of a caretaker relative must be counted. A different income calculation is used to determine countable income. Spenddown and retroactive coverage is allowed.

Prenatal Program (PN)

The Prenatal program provides full Medicaid coverage to pregnant women. The income limit for this program is 133% of the Federal Poverty Level for the household size. The program covers the mother from application through 60 days after the birth of her child. Once eligible, the woman remains eligible for the entire period. The mother does not have to comply with Duty of Support requirements while she is pregnant or for the 60 day postpartum period. **Children born to women on this program can receive Medicaid through the month of their first birthday under the postnatal program**.

Income Test: 133% of Poverty

Deductions: $90.00 work allowance, $30 and 1/3 disregard*****, and child care ($200 maximum per child under age two, $175 over age two) from earned income.
*****Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Asset limits: $5,000. Household's whose assets exceed the $5,000 limit may pay a co-payment equal to 4% of the **total** assets. The maximum co-payment is $3,367.

Retroactive coverage is allowed.

Pregnant Women (PG)

This program covers pregnant women who do not meet the income limits for the Prenatal program. The advantage of the PG program is that a woman may pay a spenddown and receive the coverage. Eligibility follows the regular FM program except that the household does not have to meet deprivation of support requirements. The woman may receive 60 day postpartum coverage if she applies for benefits before the birth of the child. Spenddown is allowed and must be met for each month of coverage including the 60 day postpartum period. The mother does not have to comply with Duty of Support requirements while she is pregnant or for the 60 day postpartum period. The child will qualify for Medicaid for the first year under the postnatal program with no spenddown.

Postnatal (PN+)

This program covers the newborn from birth to twelve months and the mother for the 60 day postpartum period. If the mother qualifies for the PN program, the 60 day postpartum coverage for the mother and child is automatic. Mothers who were not on Medicaid when the baby was born may receive the 60 days postpartum coverage and the baby may receive the year's coverage if the mother qualifies for the PN program in a retroactive month that covers the date of the birth.

At the end of the 60 day postpartum period, the household must provide verification of the birth and information about any possible insurance coverage. Application for a Social Security card will be requested, but isn't required.

A child can only receive postnatal coverage if the mother was eligible for Medicaid for the month of birth. If the mother did not qualify for Medicaid for the month of birth, the child may be eligible for the Newborn program.

Newborn Medicaid (NB)

This program provides Medicaid coverage for children from birth through age 5. Children do not have to be deprived of parental support as in the 1931 FM and regular FM programs. A child does not have to reside with the birth mother or other relative to receive coverage.

Income Limit: 133% of the Federal Poverty Level (Same as PN).

Deductions: $90.00 work allowance, $30 and 1/3 disregard, and child care ($200 maximum per child under age two, $175 over age two) from earned income.

Spend down: Not allowed.

Asset limits: None.

Retroactive coverage is allowed.

Newborn Plus Medicaid (NB+)

Medicaid coverage for children from age 6 through the month they turn 19*. Children do not have to be deprived of parental support and do not have to reside with a relative to receive coverage. The income limit for this program is 100% of the federal poverty level for the household size.
*Children who turned 18 prior to October 1, 2001 are eligible only through the month of their 18th birthday.

Income Test: 100% of poverty

Deductions: $90.00 work allowance, $30 and 1/3 disregard, and child care ($200 maximum per child under age two, $175 over age two) from earned income.

Spend down: Not allowed.

Asset limits: Same as regular FM.

Retroactive coverage is allowed.

Medically Needy Child (CM)

Households who do not meet the FM deprivation of support requirements and whose income exceeds the NB Medicaid limit, may be eligible for CM Medicaid for children under age 18 or for children between age 18 and 19 that are in school and will graduate before turning 19. Children do not have to be living with a relative and the income and assets of adult household members who are not the parents of the child are not counted. All other eligibility factors follow the guidelines under the regular Family Medicaid program.

Refugee Medical Assistance (RMA)

Refugees entering the United States are eligible to apply for Medicaid for 8 months after their date of entry. The same income and resource standards apply as for FM Medicaid. Refugee Financial Assistance automatically provides eligibility for RMA.

Medicaid Cancer Program (DM-W)

The Medicaid Cancer Program provides full Medicaid benefits to uninsured women under age 65 who have been screened for breast or cervical cancer under the CDC (Center for Disease Control) Breast and Cervical Cancer Early Detection Program and are found to need treatment for either breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The UCCP (Utah Cancer Control Program) is the CDC provider that will complete the screening. If a woman has another type of cancer but the primary cancer is breast or cervical cancer, they may still meet the requirement.

A woman must meet the general Medicaid requirements along with the following requirements:

- Screened by the UCCP
- Need treatment for breast or cervical cancer
- Has no creditable health insurance coverage which covers treatment of breast or cervical cancer
- Must be under the age of 65

Income Test: There are no income limits after meeting the income test of the UCCP.

Asset limits: None.

Retroactive coverage is allowed, but not before July 1, 2001 or prior to the woman being screened by UCCP.

Foster Care Medicaid, Title IV-E (FC/F)

The Foster Care Medicaid Program (Title IV-E) provides full Medicaid coverage to children: (1) who are in the custody of an agency within the Department of Human Services (DHS), (2) or whom a foster care maintenance payment is being made by DHS, and (3) who meet eligibility and reimbursability requirements for Title IV-E, as determined by DHS.

A child may continue to qualify for this program until age 18, or if between age 18 and 19, may qualify until the month of graduation if attending school full time and on track to graduate before the child's 19th birthday.

Income, asset and deprivation factors are as defined in the State's AFDC plan effective on July 16, 1996, except as amended by subsequent Federal Title IV-E legislation. Retroactive coverage is allowed to the date of the child's removal from the home when entering state custody.

Foster Care Medicaid, (non-IV-E) (FC/C, FC/D, FC/B)

The Foster Care Medicaid program (non-IV-E) provides full Medicaid coverage to children: (1) who are in the custody of DHS, (2) for whom a foster care maintenance payment is being made by DHS, (3) who do not meet eligibility or reimbursability requirements for Title IV-E, as determined by DHS, and (4) who meet the requirement for another Medicaid program applicable for children.

Income, assets, and other eligibility factors are as defined for other existing child Medicaid programs such as Newborn (NB), Newborn Plus (NB+), Disabled Medicaid (DM), or Child's Medicaid (CM). Continuing qualification is based on the criteria for the specific program each child qualifies under. Retroactive coverage is allowed to the date of the child's removal from home when entering state custody.

Custody Medical Care (MI-706)

The custody medical care program enables children entering foster care to immediately access health care services. The program is for foster children who have not yet had Medicaid eligibility determined, who do not qualify for any Medicaid eligibility while in custody, or who need health care services not covered by Medicaid. The program is paid for with State general funds.

This program has no income, asset or deprivation tests. The program can be authorized by DHS or a DOH Fostering Healthy Children Program Nurse for each foster child. A child may qualify for this program until state custody is discontinued.

Subsidized Adoptions

A subsidized adoption refers to the adoption of a child with special needs where an adoption assistance agreement is established between the adoptive parents and a state or local government agency. The adopted child may qualify for either title IV-E or State Adoption Assistance. A child who has an adoption assistance agreement in effect with a state or local government agency is eligible to receive Medicaid. It does not matter if the child is receiving a monthly cash subsidy. **There is no income or asset test for this type of Medicaid.**

The adoption assistance agreement usually ends the month that the child turns 18. However, the adoption assistance may extend through the month in which the child turns 21 if the child is determined to be physically, mentally or emotionally disabled by the agency originating the adoption assistance agreement. Subsidized Adoption Medicaid ends at the end of the month the adoption assistance agreement ends.

Baby Your Baby

Baby Your Baby can help finance pregnancy through a form of Prenatal Medicaid. Coverage begins the same day client is found eligible for the program. This eligibility lasts only until the last day of the next month or until Medicaid makes a determination regarding the client's eligibility, whichever occurs first. Only one Baby Your Baby Presumptive Eligibility Card can be issued per pregnancy so it is important to apply for Medicaid as soon as possible.

This card covers **outpatient pregnancy related services** while Medicaid application is processed. If the applicant is eligible for Medicaid, the Medicaid card will cover the rest of the pregnancy along with other Medicaid covered services.

To sign up for Baby Your Baby financial assistance, the pregnancy must be confirmed with a test by a doctor or clinic.

Income Limit: 133% of Federal Poverty Level.

Deductions: None calculated for the Baby Your Baby Card

Assets: None

Retroactive coverage is not allowed.

Primary Care Network -PCN

The Primary Care Network (PCN) includes 2 programs, the Primary care Network Program and the Covered at Work Program.

The Primary Care Network Program is health coverage for adults who are uninsured and do not have access to affordable insurance. The program provides a variety of preventative and medical services including: doctor visits; hospital emergency room visits; emergency medical transportation; laboratory services; x-ray services; four prescriptions per month; dental exams, x-rays, cleanings, and fillings; one eye exam per year (no glasses), family planning, and health education. Inpatient hospital services and specialty services are not covered. In addition to minimal co-pays, there is an annual enrollment fee of $50.

The Covered At Work program helps adults who qualify, pay part of the cost of health insurance through their work. Covered at work reimburses the employ up to $50 each month ($100 if their spouse is also covered) to help pay their share of the health insurance premium. There is an annual $50 enrollment fee and a 60 month lifetime limit on the program.

Age Requirement: Are age 19 through 64

Citizenship: Are a U.S. citizen or legal resident

Income Limit: Under 150% of Poverty for the household size. No deductions are allowed.

Insurance: Do not qualify for Medicaid, or have access to insurance, Medicare or Veterans Benefits, or have access to student health insurance.

Assets: No Asset requirements.

Retroactive coverage is not allowed.

Children's Health Insurance Program (CHIP)

Children's Health Insurance Program (CHIP) provides health coverage for children who are not already enrolled in a health insurance plan and do not qualify for Medicaid at no cost. In addition to minimal co-payments for office visits and services, there is a premium fee of up to $25 every three months depending on family income.

Periodic open enrollment periods will be scheduled where applications are accepted. To find out when open enrollment will be held, watch and listen for TV, radio, and other announcements, call 1-877-KIDS-NOW (toll free), or visit the CHIP website www.health.utah.gov/chip. During open enrollment application can be made by visiting the website or by visiting a Utah Department of Health eligibility office.

Age Requirement: Under age 19

Citizenship: Are a U.S. citizen or legal resident

Income limit: Under 200 % of Poverty for the household size. No deductions are allowed.

Assets: No asset limits

Retroactive coverage is not allowed.

Aged, Blind, Disabled Medical (AM, BM, DM)

Provides a Medicaid card for individuals who are Aged (65+), Blind, or Disabled. People who want to qualify on the basis of disability must meet the Social Security criteria for being disabled. Receipt of SSI or SSA disability benefits meets the criteria for disability. If the individual is not on SSI or SSA the Medicaid Medical Review Board may make a determination of disability. If disability is denied by Social Security due to Substantial Gainful Activity (SGA), the Medicaid Medical Review Board looks at disability without considering SGA.

If the person receives SSI, we do not count income of a spouse or parent; assets of a spouse or parent will be counted. The SSI person's income doesn't count toward the income limit except for Nursing Home or Home and Community Based Waiver clients. Some individuals who lose their SSI payments may still qualify without a spenddown under one of the SSI protected groups.

Income: 100% of Poverty

Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains, impairment related work expenses, health insurance premiums, and some medical bills.

Spend down: Allowed.

Asset limits: 1 person - $2,000 2 people - $3,000

Retroactive coverage is allowed.

Medicaid Work Incentive (MWI) Program

MWI is a Medicaid program for **disabled individuals** who have earned income. The household income limit is 250% of the federal poverty level. If household net income does not exceed 100% of poverty, the individual will not have any cost sharing responsibilities (MWI premium). If household net income is above 100% of poverty but below the 250% income limit, the individual will pay a MWI premium equal to 15 % of the eligible individual's income.

Income Test: Only the income of the client, a spouse living in the home and income of parents of a minor client will be counted and compared to the 250% of poverty limit.

Deductions: $20 General income disregard; the first $65 of earned income and ½ of the remaining; impairment related work expenses. Allocations for children or parents are not allowed. A spouse's income does not have to exceed the allocation to be counted in the 250% test.

MWI Premium: 15% of the eligible individual's net countable income. Must be paid in cash; medical bills are not allowed to meet the MWI premium.

Asset Limit: $15,000 for all household sizes.

Retroactive Coverage is allowed.

MEDICARE COST-SHARING PROGRAMS

There are three Medicare cost-sharing programs available to individuals with Part A Medicare benefits. These programs help cover some of the recipient's costs for Medicare services. They are not Medicaid programs, but a Medicaid recipient who is eligible for Part A Medicare may be eligible for both Medicaid and either QMB or SLMB coverage. Qualifying Individuals (QI) benefits are only available to people who are not receiving Medicaid. It is required that individuals eligible for Medicare, apply for those benefits to be eligible for Medicaid. These cost sharing programs help pay for Medicare.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program pays costs for low-income **Medicare** recipients that go along with their Medicare cards. People who receive, or are eligible to receive, Part A Medicare may apply for QMB. QMB pays Medicare Part B premiums and deductibles; the 20% co-payment of Medicare-approved amounts; and co-payments for Medicare-approved, skilled nursing home care. It can also pay Part A premiums. It takes about three months after becoming eligible for QMB for the state to begin paying the Medicare premium and the Social Security check to increase. However, QMB recipients will be reimbursed by Social Security for each month a Medicare premium was deducted and the individual had QMB eligibility. Income from a non-eligible spouse is countable. Coverage begins the first of the month following the month the client is determined eligible. A card will be issued each month. If the individual is not a recipient of Medicaid, the card will read "MEDICARE COST-SHARING ONLY."

Income limits: 100% of Poverty

Deductions: $20.00; $65 of earned income and ½ of remaining earned income.

Spend down: Not allowed.

Asset limits: 1 person - $4000
2 people - $6000

Retroactive Coverage: Not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of out-patient services including out-patient hospital services. Applicants must pass all the QMB rules, except that their income exceeds 100% of poverty and does not exceed 120% of poverty. It takes about three months after becoming eligible for SLMB for the state to begin paying the Medicare premium and the Social Security check to increase. However, SLMB recipients will be reimbursed by Social Security for each month a Medicare premium was deducted and the individual had SLMB eligibility. No card is issued for the SLMB program. An individual may be eligible for both Medicaid and SLMB.

Income limits: 120% of Poverty

Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains.

Asset limits: 1 person - $4000; 2 people - $6000

Retroactive coverage is allowed.

Qualifying Individuals (QI-1)

The QI-1 program pays the Part B Medicare premium. QI-1 eligibility criteria is the same as the SLMB program except that the income limit is higher, and the individual **cannot** be eligible for Medicaid coverage. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI-1 program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. No card is issued for the QI-1 program.

QI-1
To be eligible under the QI-1 program, an individual must meet all of the QMB eligibility requirements except that income exceeds the SLMB limit, but does not exceed 135% of poverty. For individuals eligible for the QI-1, the program pays the Medicare Part B premium only. It takes about three months after becoming eligible for the state to begin paying the Medicare premium and the Social Security check to increase. However, QI-1 recipients will be reimbursed by Social Security for each month a Medicare premium was deducted and the individual had QI-1 eligibility.

Funding is limited for this group. When funds are used up, new applicants will be denied coverage. Eligibility in future calendar years is not guaranteed.

Income limits: 135% of Poverty

Asset limits: 1 person - $4000
2 people - $6000

Retroactive coverage is allowed.

MEDICAID FOR LONG-TERM CARE

To get Medicaid to pay for long term care, people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home, or in some cases may be able to receive care in his or her own home under one of the home and community based waivers.

Nursing Home (NH)

Nursing home Medicaid will pay for nursing home and other medical costs. Some different income and asset rules apply for married couples. The patient's doctor and the nursing home must give facts about how ill the patient is to see if they qualify medically for Medicaid.

Income limits: Complicated. For single people short term (less than 6 months) eligibility is different than long term stay. The nursing home resident is able to keep $45 of monthly income for their personal needs. The rest of the money, in most cases, must be paid to the nursing home

Supplemental income: SSI recipients in nursing homes receive an SSI payment of $30 a month plus a state supplemental payment of $15.

Deductions: Complex. Under Spousal Impoverishment, a spouse at home may be allowed to keep a portion of the income of the nursing home resident for living expenses. Medical insurance premiums are an allowable deduction.

Spend down: Allowed. It is considered a contribution to care and is paid to the nursing home.

Asset limits: Complex. Under Spousal Impoverishment law, the nursing home resident is allowed $2,000.00. The spouse at home may keep ½ the total amount of countable assets. There are some exceptions. The spouse at home may keep a set amount of the assets the couple owned when the patient entered the nursing home. These amounts go up January 1st of each year.

Transfer of Assets: Transfers of assets for less than the fair market value can result in the person being ineligible (i.e., sanctioned) for nursing home Medicaid services for a period of time. When an application for Medicaid is made, the eligibility worker will request information from the prior 36 months about what the person has done with assets. This is called the look-back period. The look-back period is 60 months for assets in trusts.

Retroactive Coverage: Allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non nursing home) charges are allowed.

For more information request the pamphlet "Nursing Home Information, May we be of service to you" BES PM 969. For Married couples also request, "Assessment of Assets" BES PM 992.

Aging Home and Community Based Waiver (AW)

This waiver is a special program for clients who would be medically appropriate for institutional care. This program offers incentives for clients to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as day treatment programs, lifeline, and in-home respite care. To be eligible for this program, recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual's appropriateness for the waiver.

Income limits: 100% of poverty (adjusted annually). Only the waiver client's income counts.

Deductions: $125 earned income deduction; spousal and family allowance; health insurance premiums; medical expenses; some shelter costs.

Spend Down: Allowed

Asset Limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.

Transfer of Assets: Same as Nursing Home. Waiver services will not be paid during a sanction period.

Retroactive Coverage: Allowed. However, Waiver services received prior to the date the person met the medical criteria, as certified by the AAA worker, cannot be paid.

DD/MR Home and Community Based Waiver

A special program that helps severely disabled people of any age remain in their own homes rather than being institutionalized. Space is limited in this program. Applications are taken through the Division of Services for People with Disabilities (DSPD). One advantage of this program is that the parent's income and assets are not counted in determining a minor child's eligibility. Also, an intensive service plan is drawn up for the client. All Services are paid for by Medicaid. To be eligible for this program, clients must have been disabled before age twenty-two.

Income limits: 100% of poverty (adjusted annually)

Deductions : $830 earned income deduction; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.

Retroactive Coverage: Allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by DSPD, cannot be paid.

Technology Dependent Children Waiver

A special program which helps medically fragile children remain in their own homes rather than being institutionalized. Space is limited in this program. Children can qualify for this waiver through the month in which they turn 21. Recipients 21 and older who are admitted to the waiver prior to their 21st birthday may receive ongoing benefits. Applications are taken through the Division of Family Health Services. One advantage of this program is that none of the parent's income or assets are counted towards the child's eligibility. Also, an intensive service plan is drawn up for the client. Parents receive specialized training to learn how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. All services are paid for by Medicaid. To be eligible for this program, clients must meet specific medical criteria.

Income limits: 100% of poverty (adjusted annually)

Deductions : $125 earned income deduction; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as nursing home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.

Retroactive Coverage: Allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by the Division of Family Health Services cannot be paid.

Brain Injury Waiver

This waiver is a special program for clients who have a brain injury and would be medically appropriate for institutional care. This program offers incentives for the client to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as supported employment, day treatment programs, behavioral training, and in-home respite care. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits: 100% of poverty (adjusted annually) Only the waiver client's income is counted.

Deductions : $125 earned income deduction; some shelter expenses; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.

Retroactive coverage is allowed but not prior to the date the client met the medical criteria.

Physical Disabilities Waiver

Clients who are eligible for this waiver would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients. Additional services may include: personal care assistance, consumer training, and personal emergency response services. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD). The Physical Disabilities Waiver may not be available in all areas of the state.

Income limits: 300% of the SSI rate. If income exceeds the 300% of SSI rate, the person must spend down to the BMS and follow DM income policy. Only the waiver client's income is counted.

Deductions: If income is below 300% of the SSI rate, all income is deducted. If over 300%, deductions are the same as DM program.

Spend down: Allowed when income is over 300% of SSI.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.

Retroactive Coverage: Allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by the DSPD worker, cannot be covered.